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	291504	A. BUILDING _____ B. WING _____	05/26/2011

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ODYSSEY HOSPICE	4011-A MCLEOD DRIVE LAS VEGAS, NV 89121

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L 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your facility from 5/23/11 through 5/26/11, in accordance with 42 CFR Part 418 Conditions of Participation - Hospice Care. (Effective 10-10-10) The census was one hundred- sixty nine (169). Sixteen (16) clinical records were reviewed. Four (4) home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	L 000		
L 538	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. This STANDARD is not met as evidenced by: Based on interview and review of the care plans and care plan updates, it was determined the facility failed to ensure the care and services were specified to meet the patient and family-specific needs for 3 of 16 patients. (Patient #1, #9, #14) Findings:	L 538		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 538	Continued From page 1 Patient #1 Patient #1 was admitted to hospice program on 8/25/08 with diagnoses of failure to thrive and dementia. The patient resided in a group home. Interview Interview with the administrative staff on 5/24/11 indicated the care plans were updated on the IDG Plan of Care Review form during the IDG (interdisciplinary group) meeting. The problems identified for the patient were discussed and the Summary of Progress Toward Goals were noted on the Plan of Care Review form. The members of the IDG team signed the form and scopes/ frequency of services were noted on the form. The specific Plan of Care for each problem identified were not updated by the IDG form. There was no policies and procedures to address how the problems identified on the Plan of Care and IDG Plan of care Review form were to be integrated. The surveyor was told any medication changes were identified on the physician's orders. The current medications were not documented on the Plan of Care and the IDG Plan of Care Update. Record Review On 12/14/10, the Plan of Care for Cardiopulmonary identified Patient #1 had a history of hypertension. The interventions/approach (include changes in scope of services and frequencies) identified administer cardiac medication (s) as ordered; Educate Patient/ Caregiver about energy conserving	L 538		

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L 538	Continued From page 2	L 538		

techniques; Administer oxygen as ordered. On 4/05/11, 4/19/11, 5/3/11, and 5/17/11, the IDG documented on the Review of the IDG Plan of Care Review form under Cardiopulmonary: History of HTN (hypertension). There was no documentation by the IDG that identified Atenolol 50 mg one tablet by mouth daily was given for hypertension and the patient's response to the medication. This medication was documented on the physician's order. There was no physician order for oxygen.

On 12/14/10, the Plan of Care for Safety and Falls identified Patient #1: at risk for falls (score 19). The goal was that the patient will remain free of injury. The interventions/approach (include changes in scope of services and frequencies) identified Implement Fall Risk Reduction measures (Refer to the Pt/family (patient/family) Handbook for Hospice). On 4/5/11, the IDG documented on the Review of the IDG Plan of Care Review form under Safety/Falls Multiple: falls over 4 weeks. There was no documentation by the IDG what interventions were implemented and if the patient sustained injuries.

On 12/14/10, the Plan of Care for Pain Management identified Pain level unacceptable to patient related to the disease process. The interventions/approach (include changes in scope of services and frequencies) identified administer pain medication as ordered; Educate Pt/ caregiver on non-pharmacological methods of pain and symptoms relief to include Relaxation therapy, Educate Pt/Cg (patient/ caregiver) on medication management (see the Pt and Family Handbook for Hospice). On 4/05/11, 4/19/11, 5/3/11, and 5/17/11,the IDG documented on the

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L 538	Continued From page 3 Review of the IDG Plan of Care Review form under Pain Management: Lortab and Tylenol effective. There was no documentation by the IDG the dose and frequency for the Lortab and Tylenol pain medications. There was no documentation whether non- pharmacological method was implemented to relieved pain. On 5/3/11 ,the IDG documented on the Review of the IDG Plan of Care Review form under Skin/Pressure Ulcer: skin tear to right knee. On 5/17/11, the IDG documented on the Review of the IDG Plan of Care Review form under Skin/Pressure Ulcer: skin tears bilateral extremities. There was no documented evidence a care plan was developed for the skin tear identified to the right knee and skin tears identified to both extremities. There was no documentation that interventions were put in place to treat the skin tears. Patient #9 Patient #9 was admitted to the hospice program on 1/25/11 with a diagnosis of Failure to Thrive. Patient #9 resided in a group home. Patient #9 was admitted to the inpatient unit on 4/18/11 and discharged to the group home on 4/25/11. On 1/24/11, the Plan of Care for Cardiopulmonary identified Patient #9 had a history of hypertension. Medications Controlled. The interventions/approach (include changes in scope of services and frequencies) identified administer cardiac medication (s) as ordered; Educate Patient/ Caregiver on benefit of adherence to prescribed medication regimen; Educate Patient/ Caregiver to notify hospice regarding changes.	L 538		

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L 538	Continued From page 4 On 5/3/11, the IDG documented on the Review of the IDG Plan of Care Review form under Cardiopulmonary: started back on Atenolol- BP (blood pressure) high. There was no documentation by the IDG that identified the amount of Atenolol to be administered and the patient's expected parameter for the monitoring of the blood pressure. On 5/17/11 the IDG documented on the IDG Plan of Care Review form under Cardiopulmonary: decreased Atenolol to half. There was no documentation on the Plan of Care Review form by the IDG the dosage of the medication to be administered. On 4/5/11, the IDG documented on the Review of the IDG Plan of Care Review form under New/ Changed Medication since last IDG Meeting indicated Increase Restoril. There was no documented evidence to verify the dosage of Restoril to be administered. The Plan of Care did not address the administration of Restoril. On 5/4/11, the nurse conducted a home visit to the group home. The nurse documented "instructed _____ (name of caregiver) on medication changes." The nurse did not document the name of the medication changes. On 5/24/11 a home visit was conducted with the nurse. A review of the Hospice Medication-Treatment Profile- Physician's order, dated 4/25/11 and the Patient #9 MAR (medication administration record) at the group home was conducted with the hospice nurse. The following discrepancies were identified: The Medication-Treatment Profile- Physician's orders from the hospice, dated 4/25/11, listed the	L 538		

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L 538	Continued From page 5 following medications: Haldol 0.5 mg. (milligrams) po (by mouth) q (at) HS (hour of sleep). Tylenol 650 mg. every 4 hours prn (as needed) for pain/ temperature over 100.1 degrees. Compazine 10 mg. po every 6 hours prn for nausea / vomiting. Valium 5 mg. by mouth every 4 hours prn seizures/ anxiety. The MAR from the group home listed the following medication: Haloperidol 0.5mg one tablet twice a day. The caregiver indicated that the prn medications were not written on the MAR. The caregiver indicated the medication prn were given as needed. The hospice failed to ensure the primary care giver provided the proper care and services. Patient #14 Patient #14 was admitted to the hospice program on 1011/10 with the diagnosis of End Stage Debility. On 5/18/11 the IDG (Interdisciplinary group) Plan of Care Review identified Pain Management: Name of a medication (unable to read): and Skin/ Pressure Ulcer: dry skin prone to breakdown. There was no documentation that the pain management and skin/ pressure ulcer were addressed on the Plan of Care. The Plan of Care Knowledge Deficient, dated 12/15/10, was addressed by the IDG. Review of the IDG Plan of Care Review form , dated 5/18/11, did not address the problem of Knowledge Deficient.	L 538		
L 544	418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and	L 544		

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L 544	Continued From page 6 training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. This STANDARD is not met as evidenced by: Based on interview with caregiver and hospice nurse and record review, it was determined the hospice failed to ensure the caregiver at the group home the appropriate medication identified by the IDG (interdisciplinary group) for 1 of 16 patients. (Patient #9) Findings: Patient #9 Patient #9 was admitted to the hospice program on 1/25/11 with a diagnosis of failure to thrive. Patient #9 was admitted to the inpatient unit on 4/18/11 and discharge to the group home on 4/25/11. On 5/24/11 a home visit was conducted with the nurse. A review of the Hospice Medication-Treatment Profile- Physician's order, dated 4/25/11 and the patient's MAR (medication administration record) at the group home was conducted with the hospice nurse. The following discrepancies were identified: The Medication-Treatment Profile- Physician's orders from the hospice listed the following medications: Haldol 0.5 mg. (milligrams) po (by mouth) q (at) HS (hour of sleep). Tylenol 650 mg. every 4 hours prn (as needed) for pain/ temperature over 100.1 degrees. Compazine 10 mg. po every 6 hours prn for nausea and vomiting. Valium 5 mg. by mouth every 4 hours prn for seizures/ anxiety.	L 544		

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L 544	Continued From page 7 The MAR form the group home listed the following medication: Haloperidol 0.5mg one tablet twice a day. During the home visit on 5/24/11, the caregiver indicated that the prn medications were not written on the MAR. The caregiver indicated the prn were given as needed. The hospice failed to ensure the primary care giver provided the proper care and services.	L 544		
L 546	418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. This STANDARD is not met as evidenced by: Based on interview, clinical record and documentation review, it was determined agency failed to provide the plan of care for patients that included specific criteria for management of comfort and symptom relief for 2 of 16 patients. (Patients #7, #10). Findings: The facility's policy, "13.5-Controlled Substances, Administering PRN" (effective 2/2009 and reviewed 2/2010) contained the following documentation: " PROCEDURE-B. All PRN (take as needed) controlled substance orders that are written as ranges; (EX: Morphine 20mg (milligrams) /cc (cubic centimeters) PO (by mouth) SL (sublingual) 1cc-2cc q (every) 1-2 hours PRN	L 546		

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(take as needed) pain) will be "clarified" with the physician and re-written as separate verbal orders. EX: Morphine 20mg/cc PO/SL 20mg q 1 hr. PRN for mild pain. May repeat in 1 hour if not effective. Morphine 20mg/cc PO/SL 40mg q 1 hr. PRN for moderate pain. May repeat in one hour if not effective."

Patient #7

Patient #7 was a 97 year old admitted to hospice home care on 11/4/2009, with diagnoses of debility, high blood pressure and hypothyroidism. The patient resided at a group home.

The, "Ongoing Assessment and Update to Comprehensive Plan of Care with Physician Orders" for Patient #7 documented, "10/29/10, Restoril 30mg PO @ HS (hour of sleep) PRN insomnia, may repeat x1."
The orders did not specify how long after the first dose the second dose should have been repeated.

Patient #10

Patient #10 was a 90 year old admitted to hospice on 3/30 2011, with diagnoses of end stage congestive heart failure, cancer of the prostate, dementia and high blood pressure. The patient resided in a group home.

A Physician's Order for Patient #10 dated 3/31/2011, documented "Albuterol inhaler 3 puffs 3X (times) daily and PRN and Buspar for aggressive behavior". The order did not specify how often the Albuterol inhaler was to be used PRN and did not specify a dose for the Buspar.

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L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. This STANDARD is not met as evidenced by: Based on review of the clinical record, it was determined the hospice failed to maintain a system of communication and integration of the resident's medical condition for 1 of 16 patients. (Patient #9) Findings: Patient #9 Patient #9 was admitted to the hospice program on 1/25/11 with a diagnosis of failure to thrive. Patient #9 resided in a group home. Patient #9 was admitted to the inpatient unit on 4/18/11 and discharge to the group home on 4/25/11. On 4/18/11 at 11:00 AM, the nurse conducted a home visit in the group home. The nurse documented " received a call from _____(name of caregiver) that pt. (patient) was having a seizure or something. Arrive at facility. Pt was coming out of an unresponsive episode. per caregiver her head dropped back. her arm got stiff then started shaking. She also started drooling. Pt. eyes also rolled back. Notified	L 557		

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L 557	Continued From page 10 _____(name of IDT physician). No new orders. Notified pt husband and he stated this has happened before when she was home." On 4/18/11 at 1700 (5:00 PM), the nurse documented "received call from _____(name of caregiver) that pt was having like episode. Notified _____ (name of IDT physician). New order to transfer to inpatient unit. Husband and daughter notified." The Admission History and Physical, dated 4/18/11 was conducted by the physician. The assessment included the following: "1) Failure to Thrive with palliative performance scale of 30% and new seizure activity. We will continue with Valium P.R.N. (as needed). If the patient has seizure activity again. We will start her on Dilantin, but currently we will monitor her. " On 4/22/11 the IDG (interdisciplinary group) conducted a review/ update of the Plan of Care while the patient was in the inpatient unit, the patient will be monitored for seizure activity. On 4/25/11, the patient was discharge to the group home. On 5/3/11, the IDG Plan of Care Review form was reviewed by the IDG. There was no documented evidence on the Plan of Care Review and the Plan of Care that verified the IDG discussed the on- going monitoring of seizure activity. The Medication- Treatment Profile- Physician Order dated 4/25/11, listed Valium 5 mg. po (by mouth) every 4 hours prn for seizures/ anxiety. There were no written instructions for the caregiver at the group home, to delineate when Valium was to be given for seizure activity vs. signs and symptoms of anxiety.	L 557		

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L 620	418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. This STANDARD is not met as evidenced by: Based on interview and CNA(certified nurses aide) CE(continuing education) training documentation provided by the facility, it was determined the facility failed to ensure hospice aides received at least 12 hours of in-service training during a 12 month period for (9) of (22) employees. (Employee #6, #15, #16, #17, #18, #19, #20, #21, #22) Findings: On 4/ 25/11, an interview with administrative staff revealed the hospice had inservices provided by the facility and online continued education courses available for CNAs (certified nursing aides). The facility provided a list of CNA CE report review of the current CNA (certified nursing aides) indicated the follow employees did not receive at least 12 hours of in -service from January 1, 2010- through December 31, 2010. Employees #6, #15, #16, #17, #18, #19, #20, #21, #22.	L 620		
L 679	418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.	L 679		

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L 679	Continued From page 12 This STANDARD is not met as evidenced by: Based on record review, it was determined the hospice failed to ensure all entries in the clinical records were legible, and clear for 2 of 16 patients. (Patient #1, #10). Findings: Patient #1 Patient #1 was admitted to hospice program on 8/25/08 with diagnoses of failure to thrive and dementia. The patient resided in a group home. On 1/31/11, the nurse documented a verbal order from the physician was received. The medication initially ordered by the physician was Celexa 30 mg. (milligrams) one po (by mouth) every day. The nurse wrote over the 30 mg. and change the dosage to 40 mg. The nurse did not rewrite the order to clarify the dosage change from 30 mg. to 40 mg. Patient #10 Patient #10 was a 90 year old admitted to hospice on 3/30/2011, with diagnoses of end stage congestive heart failure, cancer of the prostate, dementia and high blood pressure. The Inpatient Physician Order and Update to Comprehensive Plan for Patient #10 dated 3/31/2011, documented "Lisinopril PO (by mouth) QD (every day) hold if BP (blood pressure) < 110/60". The medication dosage was superimposed over another which made it unclear if it was "10 mg or 20 mg (milligrams). The dosage for "Metoprolol" had a "2" written over a "1" which made it unclear if it was 15mg or	L 679		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 679	Continued From page 13 25mg.	L 679		
L 796	418.114(d)(2) CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years. This STANDARD is not met as evidenced by: Based on personnel record review, it was determined a criminal background check was not available for 1 of 11 employees (Employee #6). Findings: There was no documented evidence to verify the following CNA (certified nursing aide) had a criminal background check. Employee #6.	L 796		